Management of financial incompetence

We agree with the views expressed by Dr. Susan Lieff and colleagues in their article "Issues in determining financial competence in the elderly" (*Can Med Assoc J* 1984; 130: 1293–1296) that more flexibility is called for in the area of determining the financial competence of vulnerable individuals as well as in the management of their affairs.

The time has come for action in this area. In the last decade there have been reforms in the area of financial competence in a number of common-law jurisdictions, and a great deal has been learned as a result. In fact, recently Ontario enacted reforms to ensure that the clearly specified intentions of the donor of a power of attorney will be carried out notwithstanding the donor's being admitted to hospital and declared incompetent. But much more is needed. It is time for Ontario to reconsider the financial incompetence provisions in the Mental Health Act and the Mental Incompetency Act to ensure that they offer a modern, flexible mechanism that provides for an optimum balance between individual autonomy and protection for vulnerable individuals, one that reflects the needs and strengths of each affected individual more appropriately.

The recent changes to the Mental Health Act and the Powers of Attorney Act reflect part of the recommendations of the Ontario Law Reform Commission concerning powers of attorney. The commission should now be asked by everyone concerned with the currently unsatisfactory state of the law to undertake a major project in the area of the management of financial incompetence. It is important to support a request to the commission for action with detailed information about the inadequacy of the current law as well as some practical suggestions.

In 1978 the Province of Alberta enacted the Dependent Adults Act. This act provides for a wide range of flexible partial and temporary guardianship arrangements that can be tailored to suit the circumstances of each individual. The Alberta reforms were the culmination of many years of research and consultation. Combined with the subsequent 6 years of experience under the new legislation, the Alberta developments are one important source of information and guidance in the task of improving the laws providing for guardianship or conservatorship or both of mentally incapacitated persons in Ontario.

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Immunization of children in Calgary

Earlier this year Calgary Health Services unilaterally imposed regulations that restricted local doctors' supply of measles–mumps–rubella, diphtheria–pertussis–tetanus (DPT), DT and Sabin vaccine. Since then I have heard many complaints from my patients. A patient with *Salmonella* gastroenteritis and another with immunodeficiency who had a cold were inoculated. Patients were told that they should be inoculated even if they had a cold. In some patients induration and abscess at the site of injection developed. Premature infants were not allowed to be inoculated according to the recommended schedule. No precautions were taken for children in the high-risk group.

In view of these complaints I would like to make the following recommendations.

- Patients with colds should not be inoculated.
- Infants who were born prematurely should be inoculated with full doses of vaccine according to the recommended schedule for infants born at term and children[1] provided their clinical condition is satisfactory. These infants have less antibody response and therefore may not be adequately immunized.
- The development of screaming episodes, hypotonic–hyporesponsive episodes or convulsions following a DPT vaccination should be an absolute contraindication to further administration of pertussis vaccine.[2]
- If parents complain that their child had a reaction to a previous DPT vaccination, one should consider dividing the subsequent DPT dose into two half-doses, to be given approximately 1 week apart.[3]
- The person giving the injection should ensure that the point of the needle is not in a vein, as pertussis vaccine is markedly more pyrogenic when given intravenously.[4] Seepage of the vaccine into venules can be minimized by injecting slowly rather than with considerable pressure into loose tissues.
- The injection should be delivered intramuscularly or deeply into the subcutaneous tissue, as local abscess or induration may result from intracutaneous administration of vaccine.[5,6] Needles 5/8″ long are usually adequate for infants, but needles 7/8″ long are needed for children over 1 year of age. Care should be taken that no vaccine is present on the needle, and air should not be extruded from the preloaded syringe before injection.

Calgary Health Services claims that total public health control of immunization would increase the proportion of children immunized. This does not make sense. Inoculations are usually given as part of a routine visit to the physician. If patients cannot receive the inoculation in the doctor's office there is no guarantee that all of them would attend a health clinic.

Allegations that doctors do not keep immunization records are without grounds. Doctors in the United States perform inoculations for children. Do they also not keep good records? Or are Canadian doctors inferior to their American colleagues? The success of an immunization program depends on the cooperation of physicians, public health authorities and parents rather than restriction of access to the vaccine.

The Canadian Paediatric Society, which considers itself to be a primary advocate of good care for children, should share the concern of some of its fellows.

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[We referred Dr. Leung's letter to the Canadian Paediatric Society. Drs. John R. Waters and David W. Scheifele reply:]

The decision by Calgary Health Services to discontinue providing free vaccine to practising physicians for routine inoculation is consistent with the policy for immunization in Alberta: to deliver immunization services through the public health system whenever possible. This policy has been endorsed by the Alberta Medical Association on a number of occasions. There is no question that participation by physicians is required in individual cases, especially when other health problems exist or severe reactions are expected. However, inoculation is most effectively and efficiently administered by community health nurses specially trained in immunization principles. This has been the traditional method of delivering immunization services in Alberta, with the exception of Calgary: over 98% of inoculations in the province are given by community health nurses.

Contrary to Dr. Leung's comments there is a significant problem in record-keeping by physicians, not just in Calgary but elsewhere in Canada and in the United States. Indeed, one of the major problems in implementing mandatory inoculation in schools and controlling outbreaks of measles has been the lack of records. While many physicians do keep excellent records, a substantial number keep poor records or no records at all. Thousands of children who have probably been immunized have had to be inoculated again because there were no records.

With exclusive delivery of immunization services by community health nurses it is easier to identify children who are unimmunized and those who require follow-up than in a mixed system, where some children are inoculated at a public health clinic and others at a physician's office. The only way to identify those attending neither is with some form of computerized record system, which has attendant problems of confidentiality, or school-entry immunization requirements, which may be successful but often result in inoculation of children several years after the optimal age.

There is no question that many physicians provide excellent immunization services to their patients and that a mixed delivery system could work under ideal conditions. However, some physicians do not provide a good immunization program or find it difficult to keep up to date on changing policies and recommendations. It is our responsibility, both as public health professionals and as physicians, to minimize the impact of this. Unfortunately, to protect the greatest number this may mean measures that "penalize" good physicians and their patients. Such patients are not, however, being denied service, since a high-quality alternative immunization program is provided. Calgary Health Services has undertaken to monitor immunization to ensure that there is no decrease in the rate of immunization or compliance as a result of its new policy. The experience in the rest of Alberta and in Saskatchewan with public health delivery of vaccine suggests that a high level of immunization will be maintained.

With regard to the catalogue of criticisms in Dr. Leung's opening paragraph, inappropriate immunization practices and recognized adverse reactions are not exclusive to programs delivered by community health nurses. Indeed, in our experience, nurses are more likely to adhere strictly to formal recommendations and policies than are physicians. Dr. Leung should document errors in judgement or practice by nurses in specific instances and report them to the local medical officer of health or to my office to ensure that the error is corrected and not repeated.

With regard to the recommendations made by Dr. Leung, I offer the following comments.

- All of the national advisory bodies and most practitioners advise that colds are very common in children and are not a contraindication to immunization.[1-3] Most authorities would recommend deferring inoculation in a febrile child, although even here the contraindication is relative. Deferring inoculation in all children with simple colds would result in a large group of unimmunized children.
- It is Alberta policy that premature infants should be immunized according to their chronologic age unless the attending physician orders otherwise. This applies even to children who are still hospitalized, except that oral polio vaccine is not given to them because of the risk it might present to other children in the nursery.[4]
- Screaming episodes, hypotensive–hyporesponsive episodes or convulsions following DPT vaccination, as well as a temperature over 40.5°C and severe local reactions, should all be considered contraindications to further administration of pertussis vaccine. In such cases, however, the parents must be aware of the lack of protection their child may have against pertussis and should be advised about the need to consider erythromycin prophylaxis in the event of exposure to whooping cough.[5]
- While some recent data, such as those cited by Dr. Leung, do indicate that reactions can be re-